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The Uncontrollable Increase in U.S. Disability Rolls and The Inevitable Exhaustion of The U.S. Disability System

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1. Introduction: Defining Disability and the Need for Disability Systems

Expenditures on United States disability programs have been growing at an unsustainable pace. Since 1970, U.S. disability expenditures have grown from under \$20 billion to over \$150 billion. Growth in disability expenditures has been especially pronounced recently, increasing by nearly 50 percent during the last decade (Burkhauser and Daly, 2011). Both the Social Security Administration (SSA) and the Congressional Budget Office (CBO) predict that if serious reforms are not made in the near future, the U.S. disability system will be exhausted as early as 2018.

Despite the recent expenditure issues, there is still a big need for disability insurance in the U.S. Whether disability is short-term, lasting several months to a year, or long-term, lasting a lifetime, both physical and mental disabilities pose serious threats to economic subsistence in today's society. In 2010, 7.3 percent of the U.S. working-age population reported living with physical or mental disabilities serious enough to keep them out of the workforce (Burkhauser and Daly, 2011).

The U.S. has two separate federal disability systems: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). Both systems have the same definition of disability: "the inability to engage in a substantially gainful activity, by reason of a medically determinable physical or mental impairment that is expected to result in death or last at least 12 months." While the SSA operates both programs, SSDI and SSI target two significantly different groups of people. SSDI provides disability insurance to those forced to leave the labor force early due to mental or physical disability. SSDI benefits are typically referred to as "earnings replacement insurance" because they target those with a substantial record of employment and involvement in the workforce who are currently not working (Bound, Burkhauser and Nichols, 2001). SSI provides benefits to the blind and to working-age men and women whose disabilities are incapacitating enough to meet SSDI's eligibility but who did not participate in the workforce sufficiently enough to receive SSDI benefits. The fundamental difference between SSI and SSDI is that SSI is a means-

tested cash transfer program. In order to receive SSI, applicants must prove that their income and assets are below a “social minimum” instead of showing their employment record (Bound, Burkhauser and Nichols 2001, 3).

There are a number of theories surrounding the potential insolvency of the U.S. disability system. Some argue that the system is failing because of worsening health, declining employment rates, and an aging population (Burkhauser and Daly, 2011). However, evidence points to the opposite. While the U.S. population is aging, the population over 65 only increased by slightly over five million between 2000 and 2010 (U.S. Census, 2011). Similarly, the U.S. National Health Interview Survey found that the self-reported average health of Americans improves every year. Mortality rates have fallen by over 25 percent since 1980 and, in 1999, less than one in five Americans over the age of 65 said they lived with a disability (Autor, 2011).

These results point to the inefficiencies of the U.S. disability system. Each year, more and more work-capable Americans leave the workforce to receive federal disability benefits because of fundamental liberalizations to the program screening criteria. It is easier to receive disability benefits today than it ever has been, and the scope of what the SSA defines as a “disability” has widened considerably since the 1980s. In effect, by making it easier to apply for and receive benefits, the U.S. disability system incentivizes those with disabilities to leave work so that they qualify for benefits. Programs must encourage work and the SSA must enforce more conservative eligibility criteria. If the SSA fails to do this, current disability beneficiaries will have to turn to private methods of disability payments as early as five years from now.

2. The History and Development of the U.S. Disability System and Current Policy

The framework for the U.S. disability system began as early as the great depression. In 1936, members of the SSA sought to create a program that strictly differentiated between unemployment and disability to limit the program strictly to those who met their selection criteria. Originally, the SSA envisioned a program that provided benefits to those who had "an impairment of mind or body which continuously renders it impossible for the disabled person to follow any substantial gainful occupation," and was likely to last for "the rest of a person's life" (Berkowitz 2000, 1).

It was not until the late 1940s that the Congress passed the creation of the first Social Security disability program. Although the SSA laid out most of the initial framework, the Committee on Ways and Means was the first to present the idea of the program to Congress. Throughout the 1940s, the SSA and the Committee struggled to determine whether a federal disability system should look to rehabilitate beneficiaries or simply provide them with cash benefits. After flip-flopping between rehabilitation policy and cash insurance policy, Congress passed compromise laws in 1952 and 1954, and the original framework for the current SSDI system was finalized and passed in 1956 (Berkowitz, 2000).

2.1 SSDI History and Development

In 1956, Congress envisioned Social Security disability benefits as a policy that gave early retirement insurance to the "totally and permanently disabled." The benefits were strictly for Americans ages 50-64 who could not participate in a "substantially gainful activity," meaning work, due to physical or mental disability. In 1956, this criterion was suitable because many jobs were physically strenuous to the point where the disabled had little hope of maintaining economic independence (Autor, 2011). But between 1960 and 1984, Congress liberalized the program's selection criteria and made it easier to get benefits. In 1960, the SSA allowed workers of any age to apply for disability benefits. Five

years later, the SSA extended benefits to individuals with disabilities that medical experts anticipated to last at least one year or longer (Autor and Duggan, 2006).

In 1973, the SSA added a staple component of SSDI benefits: Medicare eligibility (Autor and Duggan, 2006). Beneficiaries now became eligible for monthly Medicare benefits after they collected disability for two years. The number of accepted beneficiaries went up drastically after this program addition and program expenditures increased so much that both President Carter and Reagan tightened the disability criteria necessary to receive benefits. Subsequently, they began “continuing disability reviews” where they cut off benefits to over 400,000 people (Autor and Duggan 2006, 74). In 1973, that was over 14 percent of beneficiaries (U.S. Census, 2011).¹

In the early 1980s, the U.S. economy experienced a recession (Ball and Mazumder, 2011). Those seeking benefits and those who had just lost their benefits incited a “national backlash” against Congress’ tightening of the SSDI program (Autor and Duggan 2006, 74). As a result, Congress ended their reviews and, in 1984, made two big changes to the program that directly led to SSDI’s current financial crisis. First, they began basing their decisions on an applicant’s “ability to function in a work-like setting” rather than basing decisions on lifelong or yearlong disabilities (Autor and Duggan 2006, 78). SSDI started to give benefits to individuals with musculoskeletal disorders such as back pain and mental disorders such as drug addiction and alcoholism. The second change altered the medical review process. Prior to 1984, the SSA held their own examinations to evaluate applicants’ disabilities. Applicants still had to provide their own medical evidence but it did not have a substantial impact on benefits decisions. But the 1984 legislation reversed the importance of the two screening methods and gave “controlling weight” to the applicant’s medical evidence instead of their own examinations (Autor and Duggan 2006, 78).

¹ This is an approximate calculation derived by dividing 400,000 by $[(.04) * 0.8[\text{the U.S. population in 1973}-(\% \text{ of individuals under } 25 \times 1973\text{pop})-(\% \text{ of individuals over } 65 \times 1973\text{pop})]]$.

These two changes represent the liberalization that is hugely responsible for the program's current financial crisis. First, by making an applicant's "ability to function in a work-like setting" the key indicator of disability, the SSA effectively opened the door to benefits for millions of more applicants. And because both pain and mental disorders have low mortality rates, the SSA pays benefits to these beneficiaries for a longer time. So while the number of beneficiaries doubled in 20 years, cash outlays tripled (Autor, 2011).² Secondly, by altering the medical review process, the SSA did not directly distribute more benefits. Instead, they made it easier for denied applicants to win appeals for benefits awards because their medical experts directly represented them in court. In 2006, medical experts and attorneys represented claimants in over 75 percent of cases. In 1997, over 80 percent of claimants won their appeals (Autor and Duggan, 2006).

Aside from program liberalization, SSDI's inefficiency at helping the moderately disabled stay in the workforce adds to their financial crisis. In 1956, many jobs involved strenuous physical activity that sometimes led to disability. But since the 1950s, the U.S. has improved workplace accommodations. The majority of workers now have flexible hours, easier jobs, and better technology; therefore many disabled people can successfully participate in the labor force and maintain economic independence. But, in effect, the SSDI program provides incentives for disabled workers to leave the labor force because they only give benefits to those who do not work. Similarly, SSDI does not give employers any incentive to accommodate disabled workers. Employers have the power to improve workplace accommodations for disabled workers, but they usually choose to save money and move them to disability rolls (Autor, 2011).

These two issues of criteria liberalization and inefficiency at keeping the moderately disabled working are not solely responsible for the financial crisis, however. Earnings for less-educated workers decrease yearly, but the value of SSDI benefits continually increases. This happens because

² The outlays values are adjusted for inflation and represented in 2009 dollars.

the SSA calculates the size of a benefits package as a “function of the worker’s earnings relative to the growth of earnings for all workers during that worker’s years of employment” (Autor and Duggan, 2006). Therefore, as the economy recedes and workers earn less, the “replacement rate” of income with SSDI benefits increases. This causes more workers to leave the workforce and apply for benefits. Medicare values also increase when the benefits package increases. The SSA paid beneficiaries \$7,700 in Medicare benefits each in 2005 compared to under \$3,500 each in 1979 (Autor and Duggan, 2006)³.

2.2 The Current SSDI System: Application Process, Funding and Benefits

SSDI is primarily financed through the Social Security payroll tax, which applies to all labor-related income. The tax finances two separate trust funds: the Old Age and Survivors Insurance Agency (OASI) fund, which funds benefits to retired Americans, and the Disability Insurance (DI) fund, through which the government pays SSDI benefits. The federal government requires all employees and self-employed individuals to pay a 12.4 percent flat tax on their earnings of which 10.6 percent goes to the OASI trust fund and 1.8 percent goes to the DI trust fund. Employees pay half of the tax (6.2 percent) and employers pay the other half up to a certain taxable maximum called the Social Security wage base amount. In 2012, this amount was \$110,100 (Autor, 2011).

The application process for SSDI is simple, however it can take over two years to complete the full process. There are several reasons why the SSDI application takes so long to process. First off, the SSA receives millions of disability applications each year. In 2010, the SSA received nearly three million SSDI applications alone. Secondly, most individuals applying for benefits cannot afford to leave work for up to two years. A drawn-out application process weeds out those individuals who left work or intentionally limited their hours solely to receive SSDI benefits (Autor, 2011).

³ These values are adjusted for inflation and are both in 2005 dollars.

Individuals first submit an application to one of 1,400 nationwide SSA offices. Each application includes proper documentation of age, work experience and medical disability evidence from the individual's health care provider. Initially, SSA employees review nonmedical criteria to make sure that individuals are under 65 years of age and that they can show proof of employment for at least five of the last ten years. Once individuals meet these qualifications, SSA employees do an earnings check. Qualified applicants cannot currently participate in a "substantially gainful activity" which, in 2006, the SSA defined as a job where earnings are above \$860 a month (Autor and Duggan, 2006).

If applicants meet the nonmedical criteria, the SSA office through which the applicant applied forwards the application to the Disability Determination Services offices. Each state government administers an office, although Disability Determination Services are actually agents of the SSA (Autor and Duggan, 2006). Here, disability examiners review the medical evidence from the applicant's health care provider regarding the applicant's ability to work. If this evidence is not sufficient enough to award the applicant benefits, the office pays for an outside medical examination for the applicant. If the application is still insufficient to receive benefits, the office then runs a comprehensive evaluation of the applicant's ability to work taking into consideration health status, education level, work experience, age, and transferability of his or her skills into a new job. If the office concludes that the applicant cannot work, they award disability benefits. If they deny these benefits, individuals can pursue three levels of appeals, where the courts eventually award benefits to over three-quarters of cases (Autor and Duggan, 2006).

Once applicants are approved to receive benefits, the SSA begins making monthly payments in the sixth full month after they approve an application. For example, if the SSA approves an individual in January, they begin making payments in July ("Disability Benefits," 2013). The SSA

calculates benefits payment amounts based on an individual's salary before he or she became disabled and the number of years an individual worked while paying social security taxes (Autor and Duggan, 2006). The higher the individual's salary before becoming disabled and the more years an individual worked while paying Social Security taxes, the higher his or her monthly benefit will be. As of March 2013, the average SSDI monthly payment was \$1,129.61 ("Monthly Statistical Snapshot, March 2013," 2013).

2.3 SSI History and Development

While Congress envisioned SSDI as an "early retirement plan," they established SSI with the intention that it would serve the population who did not work. The establishment of SSI resulted from a four-year welfare reform discussion, which began in 1969 when President Nixon proposed to replace the Aid to Families with Dependent Children program with the Family Assistance Program (FAP): a more "overarching" welfare system that provided benefits to all low-income Americans (Burkhauser and Daly, 2003). However, Congress feared the universality of the program's assistance to all low-income Americans and eventually rejected the proposal (Berkowitz, 2000). The Nixon administration then turned their attention to three other federal assistance programs created by the Social Security Act of 1935: Aid to the Blind, Aid to the Permanently and Totally Disabled, and Old-Age Assistance (Burkhauser and Daly, 2003). The administration sought to combine these three programs into an expansive welfare system that, instead of targeting all low-income Americans, targeted the subset of the poor population that was not expected to work: the aged, blind and/or disabled. In 1972, Congress combined the three programs and established the SSI program as a categorical means-based welfare program that targeted only the subset of the poor who Congress felt absolutely could not work (Burkhauser and Daly, 2003).

The current SSI system includes two programs: the SSI Disabled Adults program and the SSI Disabled Children program for children below the age of 18. SSI began paying federal benefits to both programs 1974 to those who met a series of categorical criteria. All applicants have to meet general eligibility requirements before they can be considered for more categorically based criteria (i.e. blindness, disability or age). General eligibility requirements require falling below certain income and assets limits and complying with citizenship and residency rules.⁴ The SSA considers applicants by first checking their citizenship and residency criteria. The SSA only awards benefits to U.S. citizens or “qualified aliens in an SSI-eligible noncitizen category,” which includes refugees in “refugee-like situations” or those who have served in the military (Burkhauser and Daly, 2003).

The SSA only makes payments to SSI Disabled Adults who meet an income limit called the “countable income limit.” This limit is a monthly income level federally mandated as a function of the federal benefit rate (FBR). The FBR adjusts for inflation over time by increasing with the average U.S. wage index. Typically, the government sets the countable income limit just below the U.S. Census Bureau official poverty thresholds for a given year. In 2001, the Census Bureau set the poverty threshold for single-person households at \$754 a month, while the countable income limit was \$740, a mere \$14 difference (Burkhauser and Daly, 2003).

In addition to income limits, SSI Disabled Adult applicants must fall below certain countable assets limits, which exclude the home a person lives in but include financial resources such as cash, savings, life insurance and bank accounts, and property such as land or cars (Burkhauser and Daly, 2003). However, unlike countable income limits, countable assets limits are not indexed for inflation and therefore become stricter over time. The last change in the countable assets limits was in 1989

⁴ SSI is considered “means-based” because of income and assets limit criteria.

when the government upped the limit from \$1,500 to \$2,000 for individuals and from \$2,250 to \$3,000 for couples (Burkhauser and Daly, 2003).

Each general eligibility requirement comes with certain exclusions that can either limit or increase the SSI benefits one receives. For example, not all financial or property resources count as “countable assets.” Burial plots, the home a person lives in, and life insurance plans with a face value of \$1,500 or less do not count as countable resources (“SSI Resources, 2013). While asset limit exclusions have a marginal effect benefits amounts, income limit exclusions tend to have serious negative effects. SSI beneficiaries lose \$65 in benefits for their first \$65 of labor income earned and lose an additional 50 cents per each dollar of income earned after \$65. While the SSA instituted this exclusion to make sure that only those who could not work received benefits, they instead disincentivized working for current SSI beneficiaries by making it appealing for them to leave work instead of losing benefits (Burkhauser and Daly, 2003).

Once an SSI Disabled Adult applicant meets all the general eligibility requirements, he or she can qualify for SSI benefits based on three categorical criteria: age, disability or blindness. The SSA rewards benefits to applicants as long as they meet one categorical criterion, even though some may meet two or all three. Screening for age and blindness is very simple. Those over the age of 65 are eligible for SSI benefits and must simply present valid documents to support this. Individuals are eligible for SSI benefits for blindness if they have 20/200 vision or worse accompanied by the use of corrective lenses (glasses or contacts) in their better eye, or 20 degrees or less of tunnel vision (Burkhauser and Daly, 2003).

Disability screening, however, is a much more complex process. Disability screening is subjective and there are a multitude of different definitions of disability that the SSA can use to assess impairment. However, because SSI targets a population that the SSA feels cannot be expected

to work, they chose to apply a model of disability that recognizes one's transition from impairment to a work-limiting disability: the World Health Organization's (WHO) model. This disability model "recognizes that individuals move from the presence of a health condition to a point where it begins to impinge on activities that are socially expected of them and that this movement is related to the environment in which individuals live" (Burkhauser and Daly 2003, p.86). The WHO based this disability model on one developed by Saad Nagi in the 1960s, which stresses that disability is a dynamic process that moves through three stages: pathology, impairment and disability. During the disability determination process, examiners judge one's impairment, pathology, and functioning level. However, final decisions are ultimately rooted in whether an impairment meets medical listings or whether it is severe enough where examiners expect it to last at least twelve months or result in death (Burkhauser and Daly, 2003).

Applicants for the SSI Disabled Children program must be part of families that meet the same countable income and assets requirements as applicants for the SSI Disabled Adults program. At the program's inception, the SSA paid families with disabled children benefits if the child had "a medically determinable physical or mental impairment which resulted in marked and severe functional limitations, and which was be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months." However, the Supreme Court widened the criteria in the 1990 case of *Sullivan v. Zebley*, which ruled that child disability criteria should be similar to that of adults (Burkhauser and Daly, 2003). The SSA updated the SSI Disabled Children criteria to include a disability screening process that paralleled the SSI Disabled Adults process and an Individual Functional Assessment Criteria (IFA) that paralleled a child's impairment's effect on his or her ability to attend school with an adults' impairment's work-limiting effects. These criteria changed again as a part of the 1996 welfare reform efforts, which removed the IFA criteria

and replaced it with functional equivalence criteria, which effectively narrowed the disability criteria to pre-1990 levels. Children met medical listings if they either had an extreme limitation in a single area of functioning, such as being unable to walk, or if they had two “marked” limitations in two broader areas of function, such as “personal” or “social” functionings (Burkhauser and Daly, 2003).

2.4 The Current SSI System: Application Process, Funding and Benefits

Unlike SSDI, Social Security taxes do not finance the SSI system. Instead, SSI is financed by general tax revenues generated by individual income taxes and taxes on corporations. Each year, as part of the federal budgeting process, Congress sets a limit on the maximum SSI payment the SSA can pay an individual or a couple. As of January 1, 2013, the federal limit was \$710 for individuals and \$1,066 for couples. Although there are limits for individuals and couples, there is no federally mandated limit for state caseloads (Schmidt, 2012).

The SSI Disabled Adults application process is a five-step process through which disability examination offices determine SSI benefit eligibility. The first step is where disability examiners check general eligibility requirements. Examiners make sure that applicants meet countable income and asset limits and citizenship criteria. If approved, applicants move to the second step where examiners judge impairments on whether they expect them to last 12 months or result in death. If examiners deny applicants at this step, they move to step three, where examiners check to see if applicants’ impairments match one of the medical listings. If examiners deny applicants at this stage, applicants move to the next step where examiners evaluate applicants’ “functioning ability” under Nagi’s model. Examiners deny applicants if they decide that their impairments would not limit them from returning to their past jobs. If they deem that an impairment would limit one’s ability to return to their past job, they award the applicant benefits. If examiners deny applicants at this stage, they

move to the final stage where they can appeal their case to the Social Security Appeals Council and district courts. In 2001, the SSA only awarded benefits to 10 percent of those who appealed their case (Burkhauser and Daly, 2003).

The SSI Disabled Children application process is the same as the adult process, except that steps three and four rely on the SSI Disabled Children's disability criteria rather than the SSI Disabled Adults criteria. Just as in SSDI, once examiners approve applicants in either program, the SSA begins making monthly benefit payments in the sixth full month after they approve an application. The SSA calculates the size of SSI benefit payments based on the base maximum amount, \$710 for individuals and \$1,066 for couples, less any labor income exclusions. Additionally, certain states supplement SSI payments with additional income based on labor income and living arrangements. However, not all states supplement SSI payments, and the amount of additional payments varies per state ("Annual Statistical Supplement," 2012).

3. Lessons From Past Reform

3.1 Dutch Reform

Between 1970 and 2002, loosened eligibility criteria and incentives to leave the workforce in the Dutch disability system caused a rapid and unsustainable growth in caseloads and disability rolls that led their system to near exhaustion, a strikingly similar situation to the current U.S. disability crisis. In 2002, Dutch policymakers initiated structural changes to the disability system that significantly privatized disability costs and kept more applicants off disability rolls through rehabilitation methods (Burkhauser and Daly, 2011). Because of the similarities between the Netherlands' and the U.S.' disability programs and the success of Dutch reform, the U.S. can learn from Dutch disability policy.

Similar to the U.S. system, the Dutch disability system has both an “earnings replacement insurance” program, WAO, and a program for those with little to no work history, Wajong. WAO is similar to SSDI in that it is funded by income and payroll taxes and provides benefits to those who left the workforce due to a physical or mental impairment. Wajong is similar to SSI in that it is funded by general revenue taxes and is a categorical welfare program that provides benefits to those who do not work due to a disability sustained before they entered the workforce (Burkhauser and Daly, 2011).

The Dutch caseload-per-worker ratio grew at an extremely rapid rate between 1970 and 1985.⁵ Caseload growth in the Netherlands nearly tripled during these 15 years, increasing from 40 to over 120 beneficiaries per thousand workers. Growth was especially rapid from 1975 to 1980 as Dutch beneficiaries nearly doubled from 60 to just fewer than 120 beneficiaries per thousand workers. While caseload-per-worker growth rates slowly dropped off after 1985, the percentage of the Dutch population receiving benefits continued to grow until it peaked at just over 5 percent in the early 1990s, growing from merely 1.5 percent in 1970 (Burkhauser and Daly, 2011).

The rapid growth of the Dutch disability system resulted from two changes to the system in the 1970s. The first change resulted from Dutch policymakers’ difficulty in determining whether an applicant’s lack of employment was due to health impairments or discriminatory behavior. To fix this issue, the Dutch amended their Disability Insurance Act to require that “labor-market considerations” be part of the benefits earnings determination process. This amendment required disability evaluators to attribute a partially disabled worker’s lack of employment to employer discrimination unless they could prove otherwise. Therefore, disability evaluators treated many partially disabled workers as fully disabled workers, which drastically increased the caseload-per-worker ratio. The second change was due to an increase in the Social Security tax. Dutch policymakers raised the Social Security tax

⁵ The caseload-per-worker ratio is the ratio of the number of disability caseloads to the total number of employed workers.

in the 1970s so they could keep up with increasing disability rolls. Because Dutch individuals receiving disability benefits do not pay Social Security taxes, the tax increase made it more appealing to apply for benefits (Burkhauser, Daly and de Jong, 2008).

Rising disability costs and a serious recession in the 1980s forced the Dutch government to reduce disability rolls. Between 1982 and 2002, Dutch policymakers made three major reform efforts that drastically reduced both the caseload-per-worker ratio and the percentage of the population receiving benefits. The first reform effort began in 1982 and enacted a series of cuts to the replacement rate.⁶ By 1985, the maximum replacement rate fell from 80 percent of before-tax income to 70 percent of after-tax income. These cuts reduced the total value of 1985 Dutch benefit payments by 25 percent of the 1980 value, and marginally dropped the number of caseloads (Burkhauser and Daly, 2011).

The next reform effort came in 1994. Dutch policymakers tightened the eligibility criteria, shortened to the length of disability payments, and reassessed current beneficiaries. The reforms implemented a more extensive review of the relationship between impairment and one's ability to work. This extensive review was more objective than previous reviews and classified fewer applicants as disabled. Furthermore, the reforms limited benefits payments to five years, after which disability evaluators had to reassess a beneficiary's ability to work. Lastly, in 1994 disability evaluators had to reassess all current beneficiaries under the age of 45 based on the new, more objective eligibility criteria. The 1994 reform also privatized disability costs as an attempt to encourage firms to accommodate their employees rather than motivating them to go on disability payments. Dutch policymakers made firms fully responsible for up to six weeks of an employee's sick pay. In 1996, policymakers extended this period from six weeks to one year, which resulted in a

⁶ The "replacement rate" is the percentage of an individual's income that a benefits or pension system pays in benefits. For example, under the initial WAO rules, beneficiaries could receive up to 80 percent of their previous yearly before-tax earnings in benefits.

further drop in the caseload-per-worker ratio. In 1997, this ratio fell below 100 for the first time since 1977, which was still the highest of any country with a disability system (Burkhauser and Daly, 2011).

The final and most effective reforms began in 2002 when the Dutch parliament initiated a number of reforms that resulted in the creation of a new disability system in 2004: WIA. WIA completely replaced WAO, which had been in place since 1967, and drastically altered the incentives of employers and employees by encouraging the accommodation and rehabilitation of workers following an impairment. The first structural change was the implementation of an act called the Gatekeeper Protocol, which extended the firm's responsibility for an employee's sick pay from one to two years and required firms to use a prescribed a set of accommodation and rehabilitation methods to try to keep disabled employees or find them alternative employment during the two-year sick period. After the two years are up, workers are only allowed to apply for disability benefits if they provide documentation detailing their "return-to-work efforts" and why he or she has not resumed working. If the National Social Insurance Institute (NSII) did not approve the claim, the employer became responsible for employing the worker until the NSII fully processed the claim. In 2007, close to 14 percent of claims were denied, forcing applicants back to work (Burkhauser and Daly, 2011). This act drew upon the 1994 reform by furthering employer incentives to keep employees rather than push them onto disability benefits.

The WIA also came with reforms for when the NSII approved applicants for long-term disability benefits. The NSII can place approved applicants into one of two programs. The first pays benefits to those that evaluators do not expect to recover from their disability and who have lost their earning capacity of 80 percent or more. In 2011, these beneficiaries were eligible to receive up to 75 percent of their gross earnings up to \$49,300 per year. The other system pays partial or temporary full benefits for those who evaluators expect to recover and who have lost between 35 and 80 percent of

their earnings capacity due to their disability. Beneficiaries can receive temporary benefits of up to 70 percent of their gross earnings up to \$49,300 per year (Burkhauser and Daly, 2011).

2009 marked the first year since the inception of WAO that the number of Dutch beneficiaries per thousand workers was lower than that of the U.S. In 2009, there were only 80 Dutch beneficiaries per thousand workers, the lowest number since 1976. On the other hand, in 2009 the U.S. had 82 beneficiaries per thousand workers, the highest number the U.S. has ever realized. While the Netherlands has realized a significant decline in the caseload-per-worker ratio since 2002, the U.S. ratio has been rising steadily for over two decades. Some long-term projections estimate that the three Dutch reform efforts will reduce disability beneficiaries by up to 850,000 by 2040 (Burkhauser and Daly, 2011). By privatizing disability costs to employers and decreasing the number of approved disability applicants through tightened eligibility criteria, the drastic success of Dutch disability reform gives legitimacy to potential reform of the very similar U.S. system.

3.2 1996 U.S. Welfare Reform

While the U.S. can learn from Dutch reform, policymakers can also learn from previous domestic welfare reforms. Between 1974 and 1996, the Aid to Families with Dependent Children program (AFDC), which sought to insure low-income widowed mothers, faced many of the same problems the current disability system is currently facing. Drastically increasing caseloads and benefits expenditures threatened the economic viability of the program, and the growing number of never-married women receiving benefits made policymakers skeptical of the program's legitimacy. In 1996, the U.S. replaced the Aid to Families with Dependent Children program (AFDC) with the Temporary Assistance for Needy Families program (TANF) as part of reform efforts to cut

expenditures, discourage program entry by encouraging work, and encourage current beneficiaries to return to work. The reform efforts were significantly successful (Burkhauser and Daly, 2011).

The Social Security Act created AFDC in 1935 with the initial intent to insure low-income single and particularly widowed mothers so they could stay out of the work force and take care of their children. Initially, the bulk of beneficiaries met these initial intentions. In 1940, only 10 percent of beneficiaries were never-married single mothers. However this percentage increased to 20 by 1960 and 60 by 1990 (Burkhauser and Daly, 2011). Similarly, an increasing number of widowed mothers were joining the workforce. While this is not necessarily a bad thing, it furthers the point that AFDC was inefficient in selecting to whom they would pay benefits. For nearly 20 years before the 1996 welfare reform, states initiated several experiment efforts to move never-married single mothers off of AFDC and into the labor force. States provided work programs, job training and education, and financial incentives to current AFDC beneficiaries with little success. Caseloads continued to increase and the welfare-dependency rate continued to rise steadily as well.⁷ Because of these failed reforms, states did not want to take on any more unfunded federal mandates, so they gained permission from the federal government to run broader experiment efforts. States attained “waivers” to experiment with alternative methods of paying benefits. Between 1993 and 1996, 43 states attained waivers and implemented stricter work requirements, limits on the time-period of benefits payments, benefits ceilings, and a number of other structural changes. Many of these experiments were successful and proved that a revamping of AFDC could significantly lower the number of caseloads and benefits outlays. Federal welfare reform of the AFDC system began in 1996 (Burkhauser and Daly, 2011).

⁷ To be considered “welfare dependent,” families must currently be receiving over half of their total yearly income from AFDC/TANF, SSI or food stamps (Burkhauser and Daly, 2011).

The Welfare Reform of 1996 converted the AFDC program into the TANF program. TANF has some fundamental structural differences than AFDC. Most notable was the switch from the AFDC federal matching grant to a federal block grant, which significantly cut down benefits outlays. Under AFDC, the federal government paid states unlimited funds for new beneficiaries based on their state per-capita income. Under TANF, the government pays states a fixed block grant based on state's individual AFDC expenditures from 1992 from 1995, thus eliminating unlimited benefits payments. The federal government also set limits on the amount of time one can receive benefits. Beneficiaries could only receive TANF benefits for 60 month, but the government allowed states to let 20 percent of their annual caseload continue to receive benefits. Additionally, the government imposed work requirements for beneficiaries that, if not met, affected the size of the federal block grant states received. Under the 1996 reform, 50 percent of a state's current beneficiaries needed to be working at least 30 hours a week by 2002. This requirement led states to convert welfare offices into job-placement centers in an attempt to reduce caseloads (Burkhauser and Daly, 2011).

The 1996 welfare reform was hugely successful because it changed incentives for individuals and states. Work requirements and restrictions on the length one could receive benefits reduced the incentives for one to move from full-time work to TANF benefits. Similarly, because states' block grants were effectively "penalized" if beneficiaries did not meet work requirements, they had incentives to move as many beneficiaries as possible off welfare rolls and into the workforce. After the welfare reform, AFDC/TANF caseloads dropped significantly. Over 7 percent of U.S. families received AFDC benefits in 1994. By 2010, just over 2 percent of families received TANF benefits. Similarly, nearly 70 percent of pre-reform beneficiaries were working within once they left welfare, and the average income of all U.S. female-headed, low-income households rose as a result of the reform (Burkhauser and Daly, 2011). Clearly, the impact of the 1996 welfare reform reached further

than just those involved with AFDC/TANF. If the government changes the incentives of disability benefits, similar results are possible with disability reform.

4. Trends in Disability

4.1: Overall Trends

U.S. disability caseloads have grown substantially since the 1970s. Not only have the total number of SSDI, SSI Disabled Adults and SSI Disabled Children caseloads grown respectively, but disability caseloads as a share of the population in each program have risen steadily as well. In 1981, 7.3 percent of the working-age population reported that they had a work-limiting health issue. Of this group, only 32.6 percent received disability benefits. In 2010, the percentage of the working-age population with a self-reported work-limiting health issue was about the same, but the percentage receiving benefits had increased to 51.4 percent (Burkhauser and Daly, 2011).

Over time as benefits rolls increased, the labor-force participation rate of those with disabilities decreased. In 1982, 43.2 percent of men with disabilities had some labor income. By 2009, this percentage dropped to 26.1. The trend is similar for women with disabilities, decreasing from 31 percent in 1982 to 23.4 percent in 2009 (Burkhauser and Daly, 2011). Over time, total U.S. disability program costs have increased substantially as well. Between 1974 and 2010, annual U.S. disability costs jumped from just under 20 billion to over 150 billion. Trends in the individual programs further the pressing need for reform of the disability system.

4.2 SSDI Trends

Over the last 40 years, SSDI caseloads and program costs have grown significantly faster than those of SSI. Since 1970, the number of SSDI beneficiaries has increased substantially, rising from 1.4

million to 8.3 million in 2011. The percentage of the working-age population receiving SSDI benefits rose as well, increasing from 1.3 percent in 1970 to 4.5 percent in 2011 (Elmendorf, 2012). Growing disability rolls come with rapidly growing costs as well. Between 1970 and 2011, SSDI program costs jumped from under \$20 billion to just over \$128 billion (Burkhauser and Daly, 2011).

Rapid growth in the number of caseloads is due primarily to increased liberalization in the selection criteria that allowed those with musculoskeletal disorders and mental disorders to qualify for benefits. Between 1983 and 2003, the percentage of beneficiaries with musculoskeletal disorders nearly doubled from 13.4 percent of benefits awarded to 26.3 percent. At the same time, caseloads for those with injuries, heart disease, cancer and nervous system impairments (such as paralysis) all declined (Autor and Duggan, 2006). While criteria liberalization increased caseload growth, the massive growth in program costs is also due to increases in the wage replacement rate of benefits. Between 1984 and 2002, the average wage replaced by SSDI benefits for males increased from 35 percent to 42 percent, which is \$1,129.61 monthly, on average (Autor and Duggan, 2006).

Because SSI targets a population that is not expected to work, the rise in the percentage of those with work-limiting health issues receiving any form of disability is due mainly to SSDI criteria liberalization and increased SSDI program costs. 2009 marked the first year that outlays exceeded income for the DI trust fund, which financed SSDI (“A Summary of The 2012 Annual Reports,” 2012). In 1970, SSDI and associated Medicare outlays only represented .32 percent of GDP. By 2011, these costs accounted for nearly 2 percent of GDP (“Projected Future Course for SSA Disability Programs,” 2004). The U.S. Congressional Budget Office predicts, if the program is not exhausted within the next several years, that SSDI program costs will exceed \$200 billion by the year 2022 (Elmendorf, 2012).

4.3 SSI Trends

SSI has experienced considerable caseload growth and program cost growth since its inception in 1974, however the growth is modest compared to SSDI program growth. Since 1974, caseload growth has doubled, increasing from 3.9 million to just over 8 million in 2013. Program costs have increased as well. Since 1974, program costs have increased from under \$10 billion to over \$38 billion. Despite caseload and program cost growth, SSI expenditures as a percentage of federal outlays have remained constant at 1.9 percent since 1974 (Burkhauser and Daly, 2003).

Similar to SSDI program growth, SSI program costs have risen due to increases in the benefit amount. Between 1975 and 2013, the standard benefit amount for individuals increased from \$157.70 to \$710. For couples, the benefit increased from \$236.60 to \$1,066 (“SSI Federal Payment Amounts,” 2013). However, while benefit amount increases are partially responsible for the increase in program costs, changes in selection criteria have influenced costs in both directions. Liberalized selection criteria for children in 1990 and 1996 allowed more children onto disability rolls, but the failure of the SSA to index the countable assets limit for inflation has, in effect, tightened eligibility criteria for adults.

These criteria changes are evident in the trends in the characteristics of beneficiaries. Originally, SSI targeted an aging population. In 1974, those aged 65 and over constituted most of the SSI beneficiary population. However, the total number of SSI beneficiaries over 65 has slightly decreased over time even though the total number of caseloads has doubled. In 1974, over 2.5 million SSI beneficiaries were 65 or older (Burkhauser and Daly, 2003). In 2013, this number was barely over 2 million (“Monthly Statistical Snapshot, March 2013,” 2013). Since 1974, the number of beneficiaries ages 18-64 nearly tripled, increasing from 1.5 million to just under 5 million as a result of liberalized selection criteria in the SSI Disabled Children program (Burkhauser and Daly,

2003). This is significant because many SSI Disabled Children move to SSI Disabled Adult roles when they turn 18.

5. Policy Implications and Conclusions

In 2011, the SSA estimated that three out of every ten current 20-year-old workers will be disabled before they retire (Autor, 2011). If the U.S. disability system expenditures and caseloads continue to increase the way they are currently, zero out of 20 will receive disability insurance. Disability rolls have been a staple of U.S. Social Security and welfare as early as the 1930s. However, inefficiencies in managing program growth have grown disability programs to near exhaustion. Some predict that SSDI will be insolvent as early as 2018. In 2009, the average SSDI beneficiary was 48 years old and the average value of lifetime benefits was \$270,000 (Autor, 2011). In 2010, the SSA awarded over \$124 billion in benefits and an additional \$59 billion in Medicare. These outlays totaled over 20 percent of 2010 Social Security outlays and exceeded SSDI revenue by over 30 percent (Autor, 2011). The program needs serious revamping if it has a shot to survive. A policy that experience-rates the payroll tax and provides negative incentives to employers for layoffs and positive incentives to workers to remain in the labor force can save SSDI.

This policy reforms the current SSDI system in two ways that decrease the number of SSDI beneficiaries and, thus, SSDI expenditure. The first reform entails experience-rating the current 1.8 percent payroll tax so employers who lose more workers to SSDI benefits pay more taxes. The problem with experience rating is that it makes employers liable for conditions they cannot control such as heart disease, cancer, or renal failure. Therefore, this policy's experience rating applies only to workers who claim benefits for mental disorders or musculoskeletal disorders like back pain. In effect, the government determines an employer's payroll tax as a function of the employer's workers

without life-threatening disabilities who left the workforce for SSDI benefits. Charging employers between 35 and 40 percent of SSDI benefits gives employers negative incentives for losing workers but it does not force them to take on the full burden of their benefits. Thus, this reform would spur improvement of workplace accommodations without making firms completely liable for uncontrollable medical conditions.

The policy's second reform reduces the number of less-educated and low-income SSDI beneficiaries by giving a small income replacement benefits package to denied applicants only if the SSA believes they would be successful if they appealed. The SSA adds this package to the applicant's income to equal what they would earn, in total, if they received benefits. Because the SSA calculates the size of a benefits package in relation to other worker's income, the administration indexes many low-income workers at a higher value than their income and pays them benefits more valuable than their previous income (Autor and Duggan, 2006). This reform is effective because, instead of waiting months for an appeal, denied applicants have positive incentives to enter the workforce again. SSDI expenditures and overall outlays for these workers drop significantly.

Reforming SSI should be a much simpler process than reforming SSDI. The issue with SSI is not overall caseload growth and program cost growth but the growth in SSI Disabled Children and growth in beneficiaries aged 18-64. The total number of beneficiaries over the age of 65 has decreased since 1974 despite being the target of the initial program criteria. However, the massive growth in child disability rolls goes against the initial framework of SSI. The 1990 *Sullivan v. Zebley* ruling effectively opened the door for a significantly larger child population to be eligible for benefits. Although 1996 welfare reform tightened these criteria, it was still easier for children to apply for and receive benefits than it was before 1990. Therefore, the SSA needs the disability criteria for children to match that of adults. Evaluating a child's disability based on functioning

criteria has proved inefficient. If the SSA required children to go through the same five-step process as adults and match the same set of medical listings, SSI Disabled Children caseloads would drop.

A second policy reform could tighten the ease of transitioning from SSI Disabled Children rolls to SSI Disabled Adult rolls. When SSI Disabled Children turn 18, evaluators reassess the child's disability under the SSI Disabled Adults five-step evaluation process. What this evaluation misses, however, is an accurate assessment of the 18-year-old's functioning ability in a work-like setting. Evaluators assess children based on their impairments in certain functioning areas but never assess their ability to work until they turn 18. If a policy set up a scheme where 18-year-olds were required to try working unless significantly impaired, fewer SSI Disabled Children would transfer directly over to SSI Disabled Adults benefits.

The potential insolvency of the U.S. disability system would create huge problems for a significant portion of the population. Over 16 million Americans would lose disability payments and be left to look for private forms of disability insurance. While the system could be exhausted as soon as five years from now, reform is not only possible, it is plausible. The success of Dutch disability reform gives hope to reform of the similar U.S. system, and the 1996 U.S. welfare reform gives credit to domestic reform efforts. Reform is not a simple process, especially in times of recession and economic struggle like the current situation in the U.S. However, if the U.S. hopes to continue awarding disability benefits to Americans, the federal government and the SSA must take immediate action.

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